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	150003	A. BUILDING _____ B. WING _____	04/04/2012

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FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE (	1501 HARTFORD ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital licensure survey. Dates: 4/2/2012 through 4/4/2012 Facility Number: 005003 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 04/16/12	S 000		
S 278	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(b)(2)(A)(B)(C)(D) (b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (2) Ensure that: (A) the requests of practitioners, for appointment or reappointment to practice in the hospital, are acted upon, with the advice and recommendation of the medical staff; (B) reappointments are acted upon at least biennially; (C) practitioners are granted privileges consistent with their individual training, experience, and other qualifications; and (D) this process occurs within a reasonable period of time, as	S 278		

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S 278	Continued From page 1 specified by the medical staff bylaws. This RULE is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure 3 of 4 Allied Health Care staff completed the required Health Status Confirmation Form as documented in the Medical Staff Bylaws, Policies, and Rules of Regulations of St. Elizabeth Central (#46, 47, and 48). Findings included: 1. The Governing Board approved Medical Staff Bylaws, Policies, and Rules of Regulations of St. Elizabeth Central requires all health care practitioners who are credentialed by the medical staff are to complete a Health Status Confirmation Form on condition of being appointed. 2. The credentialed files were reviewed with staff members #39 and #40. Allied Health Practitioners #46, 47, and 48's credentialed files lacked evidence showing the practitioner was healthy to perform the requested privileges he/she had applied for. 3. At 11:00 PM on 4/4/2012, staff member #39 confirmed the required Health Status Confirmation Form was not completed by the 3 of 4 allied health practitioners.	S 278		
S 318	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(F) (c) The governing board is responsible	S 318		

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S 318	Continued From page 2 for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure 2 Certified Surgical Technologists (CST) and 2 Nurse Practitioners are cardiopulmonary resuscitation (CPR) competent (#45, 46, 47, and 48). Findings included: 1. Two CST's (#45 and 46) and 2 Nurse Practitioners (#47 and 48) credentialed files lacked evidence the health care practitioners were CPR competent. The four practitioners work in the Emergency Department. 2. The Medical Staff Bylaws did not evidence CPR competency requirements for allied health workers who provide direct patient care. The CPR Training Program requires all employees who have direct patient care to provide CPR competency. The Medical Staff Bylaws require all medical staff to provide CPR Competency.	S 318		

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S 318	Continued From page 3 3. The hospital's job description for Certified Surgical Technologists (CST) minimum position requirements are CPR certification required. 4. Hospital policy #9502-11-31 requires all Register Nurses who work in the Emergency Department to have CPR, ACLS, and PALS competency. 5. At 10:45 AM on 4/4/2012, the credentialed files were reviewed with staff members #2 and #39. Staff member #39 indicated he/she does not have documentation of the allied health workers having CPR competency.	S 318		
S 322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. This RULE is not met as evidenced by: Based on observation, manufacturer's literature, and interview, the governing board failed to ensure policies and procedures were in place to ensure patient safety with the use of heated supplies.	S 322		

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S 322	Continued From page 4 Findings included: 1. During the tour of the Emergency Department at 10:40 AM on 04/02/12, accompanied by staff members #A3 and A7, a Steris Amsco warming cabinet was observed with blankets in the bottom portion and a bottle of charcoal and a container of ultrasound gel in the top portion. The cabinet displayed a temperature of 124 degrees Fahrenheit (F) for the top portion and 110 degrees for the bottom. At 10:45 AM, staff member #A7 indicated there was no documentation of temperature monitoring and he/she was unsure of what the temperatures should be. He/she also indicated the items in the top of the cabinet should not be stored there. 2. During the tour of the 2 East patient unit at 2:45 PM on 04/02/12, accompanied by staff members #A3 and A14, a small Steris Amsco warming cabinet containing blankets was observed in the linen room. A post-it note on the cabinet indicated the recommended temperature was 90 to 160 degrees F. The cabinet displayed a temperature of 153 degrees F. A Comfort Personal Care warmer was also observed in the room. At 2:50 PM, staff member #A14 indicated there was no documentation of temperature monitoring and he/she was unsure of where the temperature range on the post-it note was obtained. 3. During the tour of the Intensive Care Unit at 3:15 PM on 04/02/12, accompanied by staff members #A3 and A15, a Comfort Personal Care warmer for patient cleaning supplies was observed with a displayed temperature of 127	S 322		

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S 322	Continued From page 5 degrees F. At 3:20 PM, staff member #A15 indicated there was no documentation of temperature monitoring and he/she was unsure of what the temperature should be. 4. The information provided by the facility on the Steris warming cabinet only indicated the temperature selection range was 90 to 160 degrees F. The literature was not specific regarding temperatures other than a warning not to exceed 150 degrees F. for items with non-vented closures. 5. At 3:20 PM on 04/04/12, staff member #A2 confirmed there was no documentation of temperature monitoring on the warming cabinets or Personal Care warmers, no manufacturer's literature on the Personal Care warmers, and no policies or procedures regarding the use of the warming devices.	S 322		
S 406	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor.	S 406		

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S 406	Continued From page 6 This RULE is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure electromyography (EMG) and internal laundry services were part of its comprehensive quality assessment and improvement (QA&I) program. Findings included: 1. Franciscan St. Elizabeth Hospital Quality Improvement Plan implements all service with direct or indirect impact on patient care shall be reviewed under the quality improvement program. 2. The EMG was maintained in the Sleep Lab Department. Outside physicians use the EMG when it is needed. The facility could not provide documentation that the EMG service was being evaluated. 3. At 1:45 PM on 4/4/2012, staff member #2 indicated the PI committee does not evaluate the EMG service that the contracted physicians provide to the hospital and the hospital has no documentation to support the service being part of QA. 4. Staff member #2 could not provide documentation that the laundry service the hospital provides for their patients and their sister hospital was being evaluated. 5. At 2:00 PM on 4/4/2012, staff member #10 indicated the department had not started to QA the laundry service that the hospital was providing.	S 406		

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S 554	Continued From page 7	S 554		
S 554	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. This RULE is not met as evidenced by: Based on observation, manufacturer's directions, and interview, the staff failed to ensure a safe environment for patients by checking supplies to prevent outdated usage. Findings included: 1. During the tour of the Emergency Department (ED) at 10:40 AM on 04/02/12, accompanied by staff members #A3 and A7, the following outdated lab tubes were observed in the drawer of the supply cart: A. 7 of 10 blue top tubes expired 02/2012 B. 9 of 9 white/blue top tubes expired 03/2012 C. 1 of 8 red top tube expired 03/2012 At the nurses' station, 2 bottles of glucometer control solution were observed open, but without any dates indicating when opened or when to discard. The manufacturer's labeling indicated the solutions should be discarded 90 days after opening. At 10:45 AM, staff member #A7 indicated ED staff was responsible for checking outdates. He/she also indicated the control solutions could be used until the manufacturer's expiration date.	S 554		

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S 554	Continued From page 8 2. During the tour of the 2 East patient unit at 2:45 PM on 04/02/12, accompanied by staff members #A3 and A14, an open, but not dated, bottle of glucometer control solution was observed at the nurses' station. 3. During the tour of the Intensive Care Unit (ICU) at 3:15 PM on 04/02/12, accompanied by staff members #A3 and A15, 2 bottles of glucometer control solution were observed open, but not dated in the med room. Staff member #A15 indicated the solution was used until the manufacturer's expiration date. When the clean utility room in the ICU was checked, 21 of 22 culture swab tubes were observed with expiration dates of 07/11, 09/11, 12/11, and 01/12. Staff member #A15 indicated the storeroom staff should check the shelves when restocking. The following outdated supplies were observed in the emergency supply cart by the nurses' station: A. 3 of 3 Portex Pro-vent blood sampling kits expired 09/2011. B. 4 of 4 Vamp direct draw devices expired 10/2011. C. 1 of 3 culture swab expired 02/2012. D. 3 of 3 packets of tincture of benzoin expired 12/2010. E. 8 of 8 packets of triple antibiotic ointment expired 02/2012.	S 554		
S 596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (f) The hospital shall establish an infection control committee to monitor	S 596		

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S 596	Continued From page 9 and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iii) Cleaning, disinfection, and sterilization. This RULE is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to ensure hospital staff utilize personnel protective equipment (PPE) for chemical Cidex OPA when handled and ensure the Cidex OPA was thoroughly rinsed off of the transducer probe as required by the manufacturer and the infection control committee failed to ensure the patient care areas were cleaned and disinfected according to policy. Findings included: 1. The hospital was using Ortho-phthalaldehyde Solution (Cidex OPA), high level disinfectant for semi-critical devices, in the Radiology Department for the Ultrasound. Cidex OPA manufacture sheet requires use PPE when Cidex OPA is used. This includes: goggles, gloves, fluid resistant gowns. 2. At 1:30 PM on 4/3/2012, the Radiology Department was toured. The room where the	S 596		

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S 596	Continued From page 10 Cidex OPA was stored and utilized in the wall mounted soak station for vaginal ultrasound transducers was observed without any fluid resistant gowns and goggles available for easy access and availability. 3. At 1:30 PM on 4/3/2012, staff member #50 indicated he/she does not use PPE when handling Cidex OPA because he/she has handled chemicals all her life and knows how to handle it without PPE. The staff member indicated he/she knows PPE should be used. 4. Franciscan St. Elizabeth Health Lafayette, IN Infection Control policy #6041-!!-006, Use of Cidex-OPA for Disinfection states, "Following 12 minutes of immersion in Cidex OPA solution, thoroughly rinse device with water for at least 1 minute. Repeat step for a total of 3 times lasting 1 minute each, getting fresh water each time and thoroughly rinsing container between each rinse. These steps are important for removal of all oxidizing agent and, therefore, must be completed in its entirety without fail!" 5. Cidex OPA manufacturer technical Information booklet states, "Following removal from Cidex OPA solution, thoroughly rinse the semi-critical medical device by immersing it completely in a large volume(e.g. two gallons of water). Keep the device totally immersed for a minimum of one minute in duration. Repeat the procedure two additional times, for a total of 3 rinses." 6. At 1:30 PM on 4/3/2012, staff member #50 explained the procedure on rinsing the ultrasound transducers. The staff member indicated thoroughly rinse EV Probe in water rinse tube 30 seconds. Place cap on Cidex OPA tube, Turn off blower fan to the wall mounted soaking station.	S 596		

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S 596	Continued From page 11 Rinse probe again under running tap water for at least 90 seconds. Pat dry with clean towel, and allow to dry thoroughly before next use. The staff member indicated this was the procedure the wall mounted ventilated hood system manufacturer told him/her to do using Cidex OPA with the wall mounted soaking station. The staff member indicated this procedure has been written in a draft form and this draft procedure was what the Radiology Department was utilizing since February 2011. 7. At 11:00 AM on 4/4/2012, staff member #11 indicated he/she contacted the manufacturer of the wall mounted ventilated soaking station on 4/4/2012 and they instructed the staff member to rinse the probes according to the Cidex OPA requirements. The staff member confirmed the Radiology Department was not rinsing the ultrasound transducers as recommended by the Cidex OPA. 8. During the tour of the Emergency Department (ED) at 10:40 AM on 04/02/12, accompanied by staff members #A3 and A7, the doppler and other wall equipment and ledges in the trauma bay were observed with a heavy layer of dust. The wall equipment and suction canister in room #1 were also coated with a layer of dust. Staff member #A7 indicated the beds/carts were cleaned with the Sani-Cloth Plus wipes which had a 15 minute wait time to be effective. At 11:05 AM, housekeeping staff member, #A9, indicated he/she used the wipes for cleaning, but there was no wait time. At 11:15 AM, staff member, #A8, indicated he/she	S 596		

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S 596	Continued From page 12 used the wipes for cleaning and allowed the beds to air dry for 10 minutes. 9. During the tour of the 2 East unit at 2:45 PM on 04/02/12, accompanied by staff members #A3 and A14, the top of the warming cabinet and nearby shelves in the linen room were coated with a layer of dust. The wall oxygen, suction canister, and heating ledges in patient room #2154 were observed with a layer of dust. 10. During the tour of the off-site Mammography Center at 8:30 AM on 04/03/12, accompanied by staff members #A11 and A34, a spray bottle of Spray 2000 Neutral Disinfectant was observed in the rooms. Staff member #A34 indicated if any visible bodily fluids were observed on the equipment, the cleaner was left on for 10 minutes before wiping it off, otherwise, the spray was just used and wiped off. 11. During the tour of the off-site Lafayette Breast Center at 9:15 AM on 04/03/12, accompanied by staff members #A11 and A37, a spray bottle of Spray 2000 Neutral Disinfectant was observed in the rooms. Staff member #A37 indicated the spray was used to clean the equipment, but was rinsed off using water and paper towels because the spray broke down the covering of the equipment. 12. The manufacturer's label on the bottles of the Spray 2000 Neutral Disinfectant indicated surfaces were to remain wet for 10 minutes for effectiveness. 13. The facility policy "PDI Germicidal Disposable Cloth", last revised September 2, 2010, indicated on the first page, "...B. Using a gloved hand, apply PDI wipe to appropriate	S 596		

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S 596	Continued From page 13 surface keeping it wet for 5 minutes." 14. The facility policy "Cleaning the Occupied Patient Room", last revised December 15, 2011, indicated on the first page, "...5. Damp dust/clean the following: First using approved bleach solution on Enteric (5 minute contact time) and on all other dismissals a 1 minute contact time. Then follow up with detergent germicide solution (10 minute contact time). The facility policy for cleaning the dismissal patient room contained the same instructions.	S 596		
S 610	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators.	S 610		

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S 610	Continued From page 14 (CC) Refrigerator and freezer temperature monitoring. This RULE is not met as evidenced by: Based on observation and document review, the facility failed to maintain a clean and sanitary kitchen. Findings included: 1. At 10:30 AM on 4/2/2012, the kitchen was toured. Five prep tables throughout the kitchen were observed sticky to touch with food residue loose on the tables. Four overhead shelving units with metal doors were heavily caked with food debris on the inside and outside of the units. Three portable buffet burners were observed stored on top of each other on a food prep table with food stored on the prep table. The burners were heavily caked with dried on and loose burnt food debris on them. The Rational Oven was observed heavily soiled on the inside and outside exterior surface with food and other grease deposits. Several areas of the floor throughout the kitchen were observed with loose food on the floor. 2. Retail Food Establishment Sanitation Requirements 401 IAC 7-24-295; Equipment Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils states, "(a) Equipment food-contact surfaces and utensils shall be clean to sight and touch; (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil	S 610		

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S 610	Continued From page 15 accumulations; (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris and shall be cleaned at a frequency necessary to preclude accumulation of soil residue." 410 IAC 7-24-297; Non Potentially Hazardous Food Contact Surfaces Cleaning Frequency states, "Except when dry cleaning methods are used as specified under section 268 of this rule, surfaces of utensils and equipment contacting food that is not potentially hazardous shall be cleaned as follows: (1) At any time when contamination may have occurred; (2) At least every twenty-four (24) hours for iced tea dispensers and consumer self-service utensils, such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils, such as condiment dispensers and display containers; (4) In equipment, such as ice bins and beverage dispensing nozzles, and enclosed components of equipment, such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (A) at a frequency specified by the manufacturer; or sent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold." 3. Staff member #5 confirmed the entire kitchen needed heavy cleaning.	S 610		
S 612	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(xi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:	S 612		

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S 612	Continued From page 16 (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (xi) A program of linen management for personnel involved in linen handling. This RULE is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to ensure patient care linen are washed in 160 degrees Fahrenheit per policy. Findings included: 1. At 1:30 PM on 4/3/2012, the Environmental Services Department (EVS) was toured. In the department, there were 2 industrial washers and 1 upright home-type washer. The units were observed with hot water entering the units at 140 degrees Fahrenheit. Posted on the wall was a sign by the manufacturer indicating the 2 commercial washers have 5 separate washing stages for different type of linen that will be washed: Stage 1 - Dietary; Stage 2 - HS Color; Stage 3 - mops/rags; Stage 4 - light soil whites; and Stage 5 - Baby linen, sleep lab, scrubs. Staff member #23 operated 1 of the 2 commercial washers and started the washer as if it was washing stage 5 patient care linen. Two washing cycles were observed and the hottest wash temperature the washer reached was 134 degrees F on first cycle and 136 on the second wash cycle. The washer failed to reach 160	S 612		

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S 612	Continued From page 17 degrees Fahrenheit while washing stage 5 patient care linen. The two industrial washers injected bleach into the hot water that the washers receive. 2. At 10:00 AM on 4/4/2012, staff member #18 indicated he/she ran the commercial washers late in the evening of 4/3/2012. The staff member indicated he/she ran the commercial washers on stages 1, 3 and 5 to note the hot water temperature the stages reached and time frame the washers met or exceeded 160 degrees Fahrenheit. The staff member provided his/her notes of the washing temperature cycles. Stage 1 washed at 160 F for 12 minutes and then ran another cycle for 15 minutes at 180 F. Stage 3 washed the mop/rags at the same time and and temp as Stage 1 Dietary wash cycles did. However, Stage 5 that washes baby bedding and sleep lab bedding did not exceed 137 F during its wash cycles. 3. Franciscan St. Elizabeth Health Lafayette, IN Infection Control Plan provides guidelines for the Infection Control Plan concerning surveillance, prevention, control and education activities. The Infection Control Plan Surveillance Criteria includes adhering to Centers for Disease Control (CDC) recommendations. 4. CDC guidelines for Laundry in Health Care Facilities states, "Hot water provides an effective means of destroying microorganisms, and a temperature of at least 160 F for a minimum of 25 minutes is commonly recommended for hot washing. Chlorine bleach provides an extra margin of safety. A total available chlorine residual of 50-150 ppm is usually achieved during the bleach cycle. If hot water is used, linen should be washed with a detergent in water at	S 612		

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S 612	Continued From page 18 least 160 F for 25 minutes." 5. At 1:45 PM on 4/3/2012, staff member #10 indicated he/she required the manufacturer who recently installed the commercial washers to make sure they met the minimum 160 F minimum hot water temperature during their wash cycles. The staff member confirmed the wash cycles for washing the baby bedding and sleep lab line are not meeting the requirement of 160 F for hot water washing. 6. The manufacturer has the commercial washers set up on a schedule for wash cycle for each stage and confirmed stage 5 does not meet the minimum hot water temperature of 160 F.	S 612		
S 870	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.	S 870		

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S 870	Continued From page 19 This RULE is not met as evidenced by: Based on medical record review, policy and procedure review, and interview, the facility failed to ensure verbal/telephone orders were authenticated according to policy in 12 of 17 closed inpatient records reviewed (#N2, N3, N7, N8, N9, N10, N13, N14, N16, N17, N19, and N20). Findings included: 1. The medical record for patient #N2 indicated a verbal order on 11/14/11 that was not authenticated by the physician until 11/18/11. The record also indicated a telephone order from 11/14/11 that was not authenticated until 12/12/11. 2. The medical record for patient #N3 indicated a telephone order on 12/23/11 that was not authenticated by the physician until 12/27/11. 3. The medical record for patient #N7 indicated four telephone orders on 12/24/11 that were not authenticated by the physician until 01/05/12. 4. The medical record for patient #N8 indicated verbal orders on 12/29/11 that were not authenticated by the physician until 01/24/12. 5. The medical record for patient #N9 indicated verbal orders on 11/28/11 that were not authenticated by the physician until 12/05/11. 6. The medical record for patient #N10 indicated telephone orders on 02/24/12 that were not authenticated by the physician until 03/05/12.	S 870		

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S 870	Continued From page 20 7. The medical record for patient #N13 indicated a telephone order on 12/05/11 that was not authenticated by the physician until 12/19/11. 8. The medical record for patient #N14 indicated telephone orders on 10/19/11 that were not authenticated by the physician until 11/24/11. 9. The medical record for patient #N16 indicated a telephone order on 10/11/11 that was not authenticated by the physician until 10/23/11. 10. The medical record for patient #N17 indicated a verbal order on 01/06/12 that was not authenticated by the physician until 02/03/12. 11. The medical record for patient #N19 indicated telephone orders on 12/20/11 that were not authenticated by the physician until 12/27/11. 12. The medical record for patient #N20 indicated telephone orders on 02/22/12 that were not authenticated by the physician until 03/16/12. 13. The facility policy "Verbal or Telephone Orders", last reviewed November 29, 2011, indicated on page 1, "...3. Verbal and telephone orders must be reviewed, signed, dated and timed by the ordering physician within 48 hours." 14. At 1:15 PM on 04/04/12, the medical record findings were reviewed with staff members #A2 and A45 who confirmed the policy was not followed.	S 870		
S 932	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the	S 932		

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S 932	Continued From page 21 following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. This RULE is not met as evidenced by: Based on medical record review, policy and procedure review, and interview, the facility failed to ensure all patients had individualized care plans in 17 of 17 closed inpatient medical records reviewed (#N1-10, N13, N14, and N16-20). Findings included: 1. Review of the medical records indicated no documentation in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form for patients #N1, N2, N3, N5, N6, N8, N9, N10, N13, N18, and N20. 2. Medical record #N4 indicated "Pt/Family teaching per VTE Protocol" and "Smoking Cessation Information" documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form. 3. Medical record #N7 indicated " less than 4" as the Pain Control Goal documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form. 4. Medical record #N14 indicated "radiation @ Faith, Hope, and love. Mon., Tues., Wed., Thurs.- 10/17- 10/20, last chemo 10/8" and "ECF placement" documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form.	S 932		

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S 932	Continued From page 22 5. Medical record #N16 indicated "Don't use Heparin due to allergy" documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form. 6. Medical record #N17 indicated "Hypotensive in ER" documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form. 7. Medical record #N19 indicated "Pt. is a vegetarian" documented in the "Patient/Family Goals/Needs/Preferences" section of the Patient Care Pathway form. 8. The facility policy "Patient Plan, Guidelines for Completion", last revised June 24, 2010, indicated on the second page, "...Page 2- Care Plan: Patient Plan must be reviewed with patient and/or family and signature recorded. Each plan must include physical, social/emotional, and educational needs of the patient and family, as well as needs associated with patient discharge. A. Actual problems: 1. Pain: Circle pain scale used. 2. Record problems that must be addressed, improved, or resolved before patient discharges. Review the Patient History & Data Base for problems and concerns; document on the Patient Plan. 3. All entries must be recorded in simple terminology, not medical or nursing diagnoses. 4. All resolved patient problems will be 'yellowed out', dated, and initialed." 9. At 1:15 PM on 04/04/12, staff member #A2 indicated the facility's policy was in the process of being updated and revised, but confirmed the medical record findings and indicated the notations that were on the care plans were not true problems to be resolved.	S 932		

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S1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. This RULE is not met as evidenced by: Based on observation, policy and procedure review, and interview, the facility failed to follow its pharmacy policy regarding multidose medications and vials in the Emergency Department (ED). Findings included: 1. During the tour of the ED at 11:00 AM on 04/02/12, accompanied by staff members #A3 and A7, the following observations regarding medications were made: A. An open, 4 ounce bottle of Pseudoephedrine with an opened date of 2/15/12 in a cabinet in the nurses' station. B. An open, 4 ounce bottle of Gastrografin with an opened date of 2/05/12 in a cabinet in the nurses' station. C. An open, 10 milliliter (ml) vial of folic acid without an opened or discard by date in the medication refrigerator. D. An open, 1 ml. vial of Tubersol without an opened or discard by date in the medication refrigerator.	S1014		

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S1014	Continued From page 24 E. Two open, 20 ml. vials of Lidocaine 1% with Epinephrine without an opened or discard by date in the medication room. F. An open, 20 ml. vial of Xylocaine 1% without an opened or discard by date in the medication room. G. Two open, 30 ml. vials of Sensorcaine 0.25% without an opened or discard by date in the medication room. 2. The facility policy "Multi-Dose Vial Storage and Disposal", last reviewed August 15, 2011, indicated on page 2, "...6. Multiple dose vials containing preservatives will be dated and discarded after 28 days. 7. Multiple dose vials manufactured without preservatives will be dated, timed, and discarded after 24 hours." 3. At 11:20 AM on 04/02/12, staff member #A7 indicated all multiuse medications, oral and injectable, should be dated and discarded in 30 days.	S1014		
S1022	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions.	S1022		

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S1022	Continued From page 25 This RULE is not met as evidenced by: Based on observation, policy and procedure review, and interview, the facility failed to ensure appropriate storage of all medications. Findings included: 1. During the tour of the Emergency Department (ED) at 10:45 AM on 04/02/12, accompanied by staff members #A3 and A7, a container of charcoal for oral use was observed stored in the top portion of a warming cabinet alongside a container of ultrasound gel for external use. The temperature of that portion of the cabinet was displayed as 124 degrees Fahrenheit (F). At 10:50 AM, staff member #A7 indicated he/she did not know why those items were stored in the warming cabinet and that it was not appropriate storage conditions. 2. During the tour of the 3 East patient unit at 1:20 PM on 04/02/12, accompanied by staff members #A3 and A12, two small medication refrigerators were observed in the med room. Temperature monitoring logs were provided for the silver refrigerator, but not for the white refrigerator. When the other log was requested, staff member #A12 indicated the white refrigerator was not monitored because it was not used. However, upon inspection of the white refrigerator, 2 packaged Risperdal injections, labeled for a patient currently on the unit, were observed stored in that refrigerator. 3. During the tour of the Intensive Care Unit at 3:15 PM on 04/02/12, accompanied by staff members #A3 and A15, a small biohazard plastic bag was observed stored in the medication	S1022		

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S1022	Continued From page 26 refrigerator with emergency medications in a plastic bin labeled "Code Meds". The bag contained an open, but not dated, vial of Novolin R insulin and insulin syringes. The bag was marked with a patient sticker with an admission date of 01/02/12. Staff member #A15 indicated he/she did not recognize the name and there were no patients currently on the unit by that name. 4. The facility policy "Storage, Handling and Discarding Drugs and Biologicals", last revised June 27, 2010, indicated, "...8. All internal drugs will be stored separately from external drugs." 5. The facility policy "Patient Care Area Inspection", last reviewed January 2, 2012, indicated, "...1. Nursing Units and other patient care areas will be inspected monthly to verify the required storage and security of medications." 6. The facility policy "Refrigerator/Freezer Temperature Monitoring & Cleaning", last revised February 17, 2011, indicated, "...C. Medication refrigerators will be maintained between 36 degrees Fahrenheit (F) and 46 degrees F. or 2 degrees Celsius (C) and 6 degrees C. ...D. Temperature will be recorded: 1. All patient care areas will obtain and document temperatures twice daily."	S1022		
S1028	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(E) (d) Written policies and procedures shall be developed and implemented that include the following:	S1028		

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S1028	Continued From page 27 (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (E) Security of and authorized access to all drug storage areas within the hospital, as approved by the medical staff, when the pharmacist is absent. This RULE is not met as evidenced by: Based on observation, policy and procedure review, and interview, the facility failed to secure injectable medication stored in an off-site location. Findings included: 1. During the tour of the Lafayette Breast Center at 9:15 AM on 04/03/12, accompanied by staff members #A11, A34, and A37, a drawer filled with vials of injectable medications, Lidocaine, Bupivacaine, Sodium bicarbonate, and Epi-pens, was observed in the steriotactic room. The drawer had no lock, but staff member #A34 indicated the door could be locked when the facility was closed. 2. The facility policy "Storage and Security of Medications in Patient Care Areas", last reviewed January 11, 2011, indicated on the first page, "...B. All medications dispensed to nursing or other patient care areas will be secured, with access limited to authorized personnel. 1. Medical staff, nursing staff (nurses, unit secretaries, nurse assistants/technicians, nursing students), Environmental Services staff, and other personnel are authorized access to drug storage areas only in conjunction with their duties	S1028		

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S1028	Continued From page 28 and under supervision or personnel responsible for medication administration." The policy continued on page 2, "...A. Unit personnel with responsibility for medication administration will monitor on an ongoing basis. B. Pharmacy personnel will monitor with monthly unit audit." 3. At 9:15 AM on 04/03/12, staff members #A34 and A37 indicated there were no nurses in that unit and only the physicians could administer the medications. The staff members indicated they stocked the medication, but did not have any inventory records. They also confirmed the contracted housekeeping staff had a key to the room where the medications were stored and cleaned in the evenings without any facility staff present. 4. At 2:15 PM on 04/04/12, the pharmacy director, staff member #A38, indicated a pharmacy representative performed monthly checks of the medication storage areas and the pharmacist checked twice a year. He/she confirmed the medications should not be accessible to unauthorized personnel, visitors, or patients.	S1028		
S1118	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:	S1118		

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S1118	Continued From page 29 (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. This RULE is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (5) instances: Sleep Lab, Maintenance Department (2 instances), High Voltage Electrical Room and Distribution Center and failed to ensure the safety of the staff when handling chemicals and contaminated equipment in 3 areas (Emergency Department, 3 East, and Central Processing). Findings included: 1. The hospital Safety Management Plan policy number 9502-III-04 states, "The mission of the Safety Management Plan is to reduce and control environmental hazards and manage staff activities in order to reduce the risk of injuries." 2. The hospital Occupational Safety and Health (OSHA) policy number 952-II-52 states, "The employee shall comply with all OSHA standards as they relate to their specific job responsibilities." 3. Expert source OSHA recommends floor stand and bench mounted abrasive wheels used for external grinding shall be provided with safety guards (protection hoods). The maximum angular exposure of the grinding wheel periphery and sides shall be not more than 90 degrees, except that when work requires contact with the wheel below the horizontal plane of the spindle, the angular exposure shall not exceed 125 degrees.	S1118		

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S1118	Continued From page 30 In either case the exposure shall begin not more than 65 degrees above the horizontal plane of the spindle. Safety guards shall be strong enough to withstand the effect of a bursting wheel. 4. At 12:30 PM on 4/3/2012, maintenance room #B210 was observed with a bench mounted grinding wheel with two eye safety shields mounted on it for each wheel. However, both safety shields were adjusted upward with the safety eye shield not in a position that would protect a staff member's eyes from sparks and/or loose debris discharged from the grinding of the wheels. 5. OSHA reference 1919.303 when their was an electrical hazard observed; Electric equipment shall be free from recognized hazards that are likely to cause death or serious physical harm to employees. The hospital policies recognizes this requirement when it relates to electrical hazards that could cause physical harm to staff members. 6. At 12:45 PM on 4/3/2012, maintenance room #B210 was inspected. A wall unit Motor Control Electrical Panel (240 volt) was observed with a safety tape marking 30-inches in front of the electrical source. This tape was to let all staff know that no items of any kind can be placed within 30 inches of the electrical panel to prevent an arc from the electrical box to the item that was within 30 inches of the Motor control electrical panel. However, there were assorted equipment, cardboard boxes of supplies stored within the restricted area. 7. At 1:00 PM on 4/3/2012, High Voltage Electrical room #B102E was inspected. The high voltage room that was marked "DANGER- High Voltage" was observed with several chairs in the	S1118		

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S1118	Continued From page 31 room leaning against the electrical panels; radio boom box plugged into the wall while the antenna of the radio was in direct contact of an electrical wall mounted high voltage box; assorted clothes stored between the electrical panels; and heavy accumulation of trash and other assorted debris on the floor within the room. 8. At 1:15 PM on 4/3/2012, staff member #18 indicated the clutter that was observed in the High Voltage Electrical Room should not be there. The room needs to be kept clean to prevent physical harm to staff that are working in the room. The staff member also indicated the items observed in the restricted area in the maintenance room #B210 should be removed. 9. At 1:25 PM on 4/3/2012, the Distribution Center was toured. The room was fully sprinkled and stores assorted medical supplies and equipment for the hospital within the room on wire shelving units. The exterior walls had wire shelving racks along the exterior walls with the top shelf within 18 inches of the ceiling. There were 6 fans on the top shelves throughout the area and all of them were observed operating. If the sprinklers were activated due to a fire threat, the fans would deflect the fanning spray of water from the ceiling sprinkler heads which in turn make the sprinkler not effective against a fire spread. 10. At 9:30 AM on 4/4/2012. the Sleep Lab Department was toured. Then biohazard room was inspected and 1 of 4 walls within the room was observed with paint peeling and chipping in several places along the wall. 11. During the tour of the Emergency	S1118		

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S1118	Continued From page 32 Department (ED) at 11:00 AM on 04/02/12, accompanied by staff members #A3 and A7, the chemical "Dispatch" was observed stored in the housekeeping closet. The label on the container indicated eyes were supposed to be flushed for 15 to 20 minutes if splashed with the chemical. At 11:40 AM, the housekeeping staff member, #A9, indicated the chemical was poured into a container with wipes to be used for cleaning. At 11:45 AM, the environmental services director, staff member #A10, confirmed there was no eyewash station available for emergency use in the closet or surrounding area. 12. During the tour of the 3 East patient unit at 1:40 PM on 04/02/12, accompanied by staff members #A3 and A12, the chemical "Dispatch" was observed in the housekeeping closet. The staff members confirmed there was no eyewash station in the closet or surrounding area for emergency use. At 2:00 PM, the housekeeping staff member, #A13, indicated the chemical was poured into a container with wipes to be used for cleaning. 13. During the tour of the Central Sterile Processing Department at 10:20 AM on 04/04/12, accompanied by staff members #A4 and A46, a wall mounted "Flash Flood" emergency eyewash station was observed by the sink in the clean room. The label on the unit indicated it was installed 06/09/11 and should be replaced 6 months after installation, which would have been December 2011. Another eyewash station was observed on the wall by the sink in the decontamination room.	S1118		

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S1118	Continued From page 33 Handwritten dates of 03/03/09, 09/03/09, 04/21/09/ and 08/17/09 were observed on the label with a signature of a facility maintenance staff member. The label also had a manufacturer's expiration date of 07/2011 that was written over and changed to 07/2012. No explanation for these dates could be provided by facility staff prior to exit. 14. The facility policy "Shower and Eyewash Stations, last revised 12/12/2011, indicated, "...An eyewash station should be within ten seconds or 100 feet from the place where hazardous chemicals are used."	S1118		
S1124	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(5)(A) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (5) Provision shall be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows: (A) Operation, maintenance, and spare parts manuals shall be available, along with training or instruction of the appropriate personnel, in the maintenance and operation of the fixed and movable equipment.	S1124		

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S1124	Continued From page 34 This RULE is not met as evidenced by: Based on observation, manufacturer's literature, and interview, the facility failed to ensure preventive maintenance was performed on all equipment to ensure patient safety. Findings included: 1. During the tour of the Emergency Department at 10:40 AM on 04/02/12, accompanied by staff members #A3 and A7, a Steris Amsco warming cabinet was observed with blankets in the bottom portion and a bottle of charcoal and a container of ultrasound gel in the top portion. No preventive maintenance information was observed on the unit. 2. During the tour of the 2 East patient unit at 2:45 PM on 04/02/12, accompanied by staff members #A3 and A14, a small Steris Amsco warming cabinet containing blankets was observed in the linen room. A post-it note on the cabinet indicated the recommended temperature was 90 to 160 degrees F. A Comfort Personal Care warmer was also observed in the room. No preventive maintenance information was observed on either of the units. 3. During the tour of the Intensive Care Unit at 3:15 PM on 04/02/12, accompanied by staff members #A3 and A15, a Comfort Personal Care warmer for patient cleaning supplies was observed with a displayed temperature of 127 degrees F. No preventive maintenance information was observed on the unit. 4. During the tour of the off-site Women's Health Specialty Therapy room at 8:55 AM on 04/03/12,	S1124		

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S1124	Continued From page 35 accompanied by staff members #A11, A35, and A36, a hydrocollator for warming patient devices was observed with a sticker indicating it had been tested on 05/09. Staff members #A35 and A36 indicated the equipment had just been given to that site from a sister facility in February. The staff members indicated it had been checked by maintenance and had just not been restickered. 5. At 3:20 PM on 04/04/12, staff member #A2 confirmed there was no documentation of preventive maintenance on any of the warmers and no documentation of preventive maintenance on the hydroccolater before it was put into use in the therapy room.	S1124		
S1164	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. This RULE is not met as evidenced by: Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on Environmental Service's Automatic Scrubbers. Findings included:	S1164		

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S1164	Continued From page 36 1. Staff member #20 provided owner manuals for 3 automatic scrubbers the hospital utilizes: Betco Watchmen; Razor Blade; and Saber Compact. Betco Watchman periodic inspections includes daily, weekly, and semi-annually maintenance inspections. The other two floor automatic scrubbers require the same routine periodic inspections as the Watchman automatic scrubber required. Staff member #20 did not produce any documentation that the three types of automatic scrubbers receive preventive maintenance as recommended by the manufacture. 2. At 2:45 PM on 4/4/2012, staff member #20 indicated the floor scrubbers are being inspected when the manufacture needs to be called because the scrubber quit operating. The staff member indicated his/her department does not have a routine preventive maintenance schedule for the hospital's automatic floor scrubbers.	S1164		